MaineCare
Health Care for Maine People

Billing Instructions

Claim Form **UB-92**

Mail Claim(s) To:	Medical Assistance Claims Processing M-100 Augusta, Maine 04333

It is important for you to have current CPT, ICD diagnostic and HCPCS code books in order to bill appropriately. Note: these instructions are general for all providers using the UB92. Please see addendum for your specific provider type.

The provider of service must purchase UB-92 claim forms, without bar codes. **(The Bureau of Medical Services does not sell these forms).** You can also bill electronically through EMC batch billing or over the web when MECMS is implemented.

APPROVED OMB NO. 0938-0279

	2				3 PATIENT CONTROL NO				
	5 FED. TAX NO	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D	9 C-I D	10 L-R D.	11	
12 PATIENT NAME		13 PATIENT ADDRESS							
14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO
24 CONDITION CODES									
31									
32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM THROUGH
37 A B C									
38	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT			
a b c d									

	42 REV CD	43 DESCRIPTION	44 HCPCS / RATES	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1								
2								
3								
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	50 PAYER	51 PROVIDER NO.	52 REL. BEN.	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A							
B							
C							
57		DUE FROM PATIENT ▶					

	58 INSURED'S NAME	59 P REL	60 CERT - SSN - HIC ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO
A					
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A				
B				
C				

67 PRIN DIAG CD	OTHER DIAG. CODES 68 CODE	EXTERNAL	69 CODE	EXTERNAL	70 CODE	EXTERNAL	71 CODE	EXTERNAL	72 CODE	EXTERNAL	73 CODE	EXTERNAL	74 CODE	EXTERNAL	75 ADM DIAG CD	77 E-CODE	78

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

	82 ATTENDING PHYS. ID
a	
b	
a	83 OTHER PHYS. ID
b	
a	OTHER PHYS. ID
b	

	84 REMARKS
a	
b	
c	
d	

85 PROVIDER REPRESENTATIVE X — 86 DATE

UB-92 HCFA-1450 — OCR / Original

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

Instructions for Completing UB-92 for Maine Care Covered Services

The form locator requirements are taken from the UB-92 manual developed by the National Uniform Billing Committee and approved by the State of Maine Uniform Billing Committee. Please contact the State of Maine Uniform Billing Committee for the complete manual.

Only the required fields are addressed.

Do not overlap information into other fields.

The top of the claim form must be left blank. MaineCare uses this area to stamp a unique transaction control number (TCN). If you purchase claim forms with a bar code you must cover that area before submitting your claim to Maine Care or the claim will be returned to you.

FL = Form Locator

FL01: Minimum requirement is the provider's name, city, state and zip code. The telephone number is helpful in contacting the provider, if necessary. The complete mailing address is necessary to ensure prompt payment to provider.

FL02: Leave Blank (**Payer Use Only)**. MaineCare assigns a unique Transaction Control Number (TCN) to each claim received. The TCN appears on your remittance statement in the left-hand column.

FL03: Patient control number assigned by the provider.

FL04: Type of Bill, 3 or 4 digits. Please see the UB-92 manual for specific codes.

FL05: Federal Tax Number (Employer Identification Number – EIN). This number is required for Federal income tax purposes.

FL06: The beginning and ending service dates of the period included on the bill. For all services received on a single day, use both the "From" and "Through" dates, i.e. both will be the same date. Enter both dates as month, day, and year (MMDDYY). Example: 060102.

Outpatient claims must be billed based on one calendar month per claim.

FL07: The number of days covered for inpatient bills. Do not include discharge date in the covered days.

FL08: Number of days not covered. The reason for non-coverage should be explained by occurrence codes, conditions codes or remarks.

FL09: Not required.

FL10: Lifetime Reserve Days (Medicare).

FL11: Not required.

FL12: Patient's name must be entered in the order of by last name, first name and middle initial. The first three letters of the last name must match MaineCare files. If they do not, the claim will be denied for incorrect name.

FL13: Patient's address.

FL14: Patient's date of birth in eight-digit format. (MMDDYYYY)

FL15: Patient's sex. "M" or "F."

FL16: Not required.

FL17: Enter the date of admission for inpatient services or enter the date of service for an outpatient claim. (MMDDYY). Please note, if the admission date is entered incorrectly as being after the "from date" in FL06, your claim will deny for invalid dates billed.

FL18: Admission hour for inpatient bills only. Please see the UB-92 manual for specific codes (hospital only).

FL19: Type of admission is required for inpatient services (hospital only).

FL20: Source of admission for inpatient admissions and outpatient registrations. Please see the UB-92 manual for specific codes.

FL21: Discharge hour is the hour that the patient was discharged from inpatient care. Please see the UB-92 manual for specific codes (hospital only).

FL22: A code indicating patient status as of the statement-covers-period-through date (FL06). The day of discharge is not a MaineCare covered day and must not be included in the total covered days in FL 07. If a patient's discharge code does not correspond to the number of days indicated in FL 04, 06, 07 and 46, then the claim will deny for invalid dates billed. Please see the UB-92 manual for specific codes.

FL23: The number assigned to the patient's medical/health record by the provider.

FL24 – FL30: Codes used to identify conditions relating to the bill that may affect payer processing are required, if applicable. Please see the UB-92 manual for specific codes. *** **Code 80** used for involuntary acute care admission (other than AMHI and BMHI). Also use **code AJ** to bypass MaineCare co-pay requirement (as allowed by the MaineCare Benefits Manual). This would refer to emergency services as well.

FL31: Not required.

FL32 – FL35: The code and associated date defining a significant event relating to the bill that may affect payer processing is required, if applicable. Please see the UB-92 manual for specific codes.

FL36: A code and related dates that identify an event that relates to the payment of the claim is required, if applicable. Please see the UB-92 manual for specific codes.

FL37: Enter the TCN of the claim being adjusted or voided.

FL38: Not required.

FL39 – FL41: When a MaineCare patient has a spenddown or is responsible for an assessment/cost of care, that information must be entered in FL39. The following will be used:

23 = Patient assessment/cost of care
A1 = Deductible Payer A (B1, C1…)
A2 = Coinsurance Payer A (B2,C2…)
D3 = Spenddown

Please see the UB-92 manual for complete instructions and specific codes as appropriate.

FL42: A code, which identifies a specific accommodation, ancillary service or billing calculation. Please see the UB-92 manual for specific codes.

See attached supplement for more information regarding revenue codes.

FL43: Not required.

FL44: The accommodation rate for inpatient bills. Outpatient bills require the use of the HCFA Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes.

Various CPT and HCPCS codes may require the use of modifiers to improve the accuracy of coding. The appropriate modifier should be reported along with the procedure code.

FL45: The date the indicated service was provided for outpatient claims for occupational, physical and speech therapy services (series bill). Only one calendar month can be billed on a claim form.

FL46: Required for inpatient accommodations. The number of days indicated in this FL for units must equal the number in FL07.

For outpatient claims, this FL must be used if the same service is provided more than once on the same day. For example, two of the same EKG on the same date, you would indicate two units.

FL47: Total charges pertaining to the related revenue code for the current billing period as entered in the statement covers period. (FL 06, 07 and 08)

A line item cannot exceed $99,999.99. If room charges exceed this amount, the charges must be split into two lines.

No more than 20 line items can be billed per claim. The **total** line (rev code 001) can be billed in addition to the 20 lines. Claims cannot be continued onto a second page. Each claim form must be totaled as each claim form is considered separately. In the remarks section (FL84), write, "Split Bill, two claims for the same admit".
The figures in column 47 add up to a **total**, which is using revenue code 001.

FL48: Enter non-covered charges pertaining to the related revenue code, if applicable.

FL49: Not required.

FL50: Code and name identifying each payer organization from which the provider might expect some payment for the bill. MaineCare is the payer of last resort.

Line A = Primary payer
Line B = Secondary payer
Line C = Tertiary payer

Code C = Medicare
Code D = MaineCare
Code G = Blue Cross
Code F = Other

Example: If a patient has Blue Cross, FL50 would be as follows:

Line A = G for Blue Cross
Line B = D for MaineCare

Lines in FL50 must correspond to lines in FL51, FL54, FL58, FL59, FL60, FL61 and FL62.

FL51: The number assigned to the provider by the payer indicated in FL50, Lines A, B and C. MaineCare assigns a nine-digit provider number to providers. If MaineCare is secondary as in the example above, the MaineCare provider number would be in line B.

FL52: Not required.

FL53: Not required.

FL54: Prior payments received from other third party payers except Medicare. Never put a prior MaineCare payment in this FL. Maine Care's system knows if you have been paid on certain line items and will deny those specific line items as duplications. If third party payment exceeds Maine Care reimbursement, no additional payment will be made.

If you are in a contractual agreement with a private insurance company to accept their payment as payment in full, you cannot bill MaineCare for charges. You will get rejected for the reason "no balance due."

FL55: Not required.

FL56: Not required.

FL57: Not required.

FL58: Insured's last name, first name and middle initial. Name must correspond with the name on the MaineCare ID card. For MaineCare purposes, the patient is considered the insured.

FL59: Please see the UB-92 manual for specific codes. If a patient has insurance through a third party, use the code that indicates the relationship.

FL60: MaineCare ID number as shown on the MaineCare card. Remember to use the appropriate line (A, B or C) that corresponds to FL50.

FL61: Insured's group name, if applicable. Primary payer information required if Maine Care secondary.

FL62: Insurance group number, if applicable. Primary payer information required if Maine Care secondary.

FL63: The following information must be reported in this field when applicable:

A. Maine Care Managed Care Referral Number (formally PrimeCare Number).

B. **PA Number.** Some services required prior authorization. The source of the PA usually is the Bureau of Medical Services, Professional Claims Review Unit/PA Unit. But PAs may be authorized by other sources; eg. MaineCare Eye Care, Breast & Cervical Health Program.

C. **BDS Authorization Number.** This is an internal contract number issued by DHHS.

FL64: A code used to define the employment status of the insured individual identified in FL58, if applicable. Please see the UB-92 manual for specific codes.

FL65: Employer name that provides health care coverage, if applicable.

FL66: Not required.

FL67: The primary diagnostic ICD9-CM code.

FL68 – FL75: The ICD9-CM diagnosis codes corresponding to additional conditions that co-exist at the time of admission, or develop subsequently, and which have an effect on the treatment received or the length of stay.

FL76: Not required.

FL77: Not required.

FL78: Not required.

FL79: Procedure coding method used, if applicable.

FL80: Enter the code identifying the principal surgical or obstetrical procedure. Date is required in six-digit format. (MMDDYY)

FL81: Enter the code identifying the other surgical or obstetrical procedures. Date is required in six-digit format. (MMDDYY)

FL82: Attending physician's Unique Physician Identification Number (UPIN).

FL83: Other physician UPIN.

FL84: Remarks, when applicable. Use recommended format. Example: Insurance explanation attached.

FL85: Provider representative signature, facsimile signature acceptable. "Signature on file" is **not** acceptable.

FL86: Date bill submitted. (MMDDYY) Claims are rejected if this date is missing or incomplete or if it is prior to dates of services.